

# Monroe County

*Long Term Care Council:*



ALTERNATE LEVEL OF CARE STUDY



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# Alternative Level of Care Study

## *Prologue*

In 2004 in his State and Budget messages then Governor, Pataki announced comprehensive efforts to reform the long term care system. The Governor declared, “These efforts will provide the services that help the elderly stay in their own homes where they’ve lived their lives, raised their children and built their memories...”

The New York State Office for the Aging and Department of Health began working collaboratively on designing NY Connects.

The NY Connects partnership between the New York State Department of Health (NYSDOH) and the New York State Office for the Aging goals are a consumer focused approach to providing the following services:

- 1) Comprehensive and unbiased information and assistance to all services and supports.
- 2) The opportunity of consumers, regardless of payer source, to be screened to ascertain an individual’s general social and medical needs and financial status, and to direct them to available service options.
- 3) After the initial screening, a comprehensive needs assessment to identify the supports needed to maintain the highest level of functionality.
- 4) Available to all for all individuals who require it
- 5) Public Education component that assists consumers to prepare financially for their long-term care needs.
- 6) An interdisciplinary team approach to more effectively coordinate and manage services for those individuals in the system.

One of the mandates for becoming a NY Connects site, the sponsor agency is required to form a Long Term Care Council. The primary role of the Council is to advise the County Executive, The Commissioner of Human Services, and the Director of the Office for the Aging on long-term care issues facing Monroe County, and to ensure achievement of the goals and objectives of NY Connects.

## **I. Context**

Monroe County, at the request of New York State Office for Aging, established a Long Term Care Council. The purposes of these councils are to simplify access to long term care services; to identify and address gaps in the service delivery systems, to identify barriers to accessing care, and to work to transform services to patient centered care.

## **II. Rationale for Studying Alternate Care**

As the Monroe County Long Term Care Council (MCLTCC) began to assess gaps in services and barriers to care, care management rose to the top of the list in regards to issues facing Monroe County. Care management was also identified as the second most prevalent issue across NY State NY Connects programs. Based on this consensus, the Care management work group began to define the issue of Care management, it became evident that hospitals were the place that people in need of long term care services frequently arrived when: people required care and had no care givers; when care givers

burned out, or when care plans provided by community support services, home health agencies or residential facilities were no longer adequate. Appendix 1 provides a chart of key issues identified by the MCLTCC. Care Management, which was ranked as the highest problem area by the Council was then further broken down into its component parts.

Those patients who are admitted to hospitals for social purposes when there are not safe discharge alternatives from the emergency room, and those patients who remain in hospitals after their acute care needs have been met, are called “alternate care patients” (ALC patients). This term is used to describe patients who are being cared for in hospitals because there are barriers to their immediate access to the right level of care at the most appropriate sight to address their needs.

The ALC patients were selected because these patients are a cohort of individuals who are not able to access the most appropriate care in a timely way. They provide an efficient way to identify some of the current gaps in services and barriers to care.

It is also appropriate to address the needs of this population because research indicates that hospitals can present risks to patient’s health and functional status.<sup>1</sup> While hospitals can be essential to saving lives, returning the patient to his/her optimal health and functional status is often accomplished best at home or in a rehabilitation setting. Studies have shown that hospitalized patients, especially older adults, are at risk of acquiring infections,<sup>2</sup> becoming disoriented,<sup>3</sup> becoming depressed,<sup>4</sup> and losing their mobility if they remain in hospitals beyond the medical necessity for their being hospitalized.<sup>5</sup>

From the community’s perspective it is also appropriate that the Council studied the needs of the alternate care population. Each bed day that is used for a person on alternate care, represents a day of acute care that is not available to a patient who requires hospital care. This diversion of acute care beds to alternate care use has the potential to become a community crisis when emergency rooms go to “code red” and have to divert ambulances, because the emergency room is holding patients who require hospital admission and there are no acute beds available.

It is also important to address the alternate care problem, because it represents an excessive expenditure of health care resources for care that does not represent best practice standards.

Before proceeding, it is important to note that as this study and others have shown, alternate care is a symptom of an array of problems in the organization, delivery, and financing of care for those who are elderly and those who live with chronic illnesses. While the locus for the study is patients in hospitals, hospitals per se are not the problem. Rather, they have become the safety net for people experiencing barriers to care.

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2. [www.healthUSNews.com/blogs/Comarow\\_A](http://www.healthUSNews.com/blogs/Comarow_A). “An Outbreak of Hospital Infection Talk.” October 7, 2008.

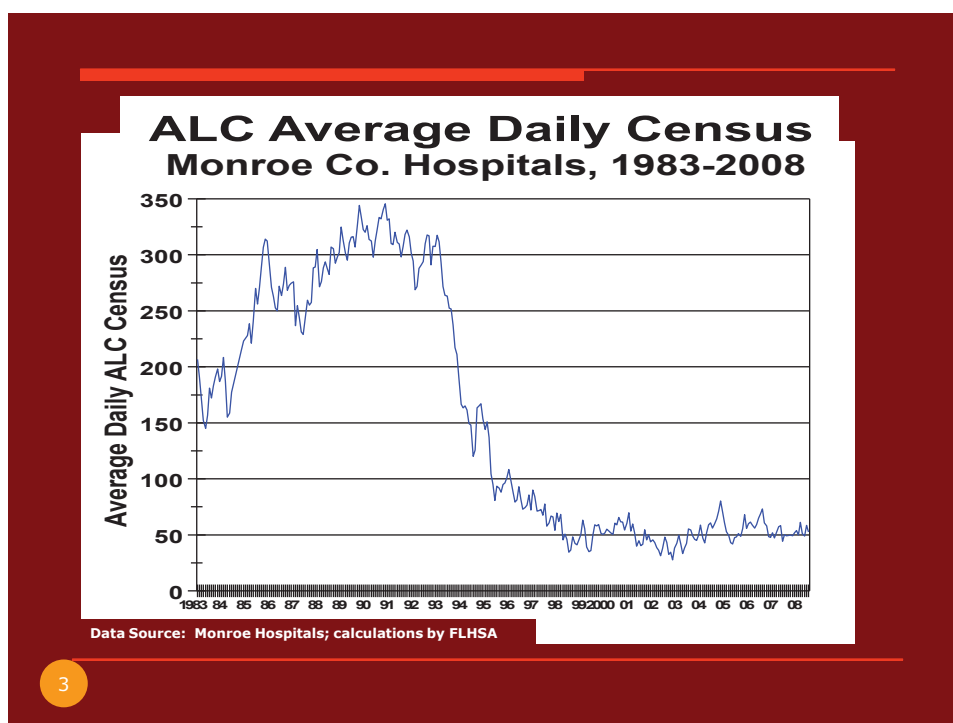
3. [www.hospitalelderlifeprogram.org](http://www.hospitalelderlifeprogram.org).

4. [www.medwelljournals.com/fulltext/rjbs/2008/1018-1021](http://www.medwelljournals.com/fulltext/rjbs/2008/1018-1021). Ghoreishizadeh, MA et.al. “Depression Among General Hospital Surgical Inpatients and Its Effect on Length of Hospital Stay.” Research Journal of Biological Sciences 3(9) 1018-1021, 2008.

5. Chris MacKnight, Kenneth Rockwood. “A hierarchical assessment of balance and mobility,” Age and Ageing, March, 1995

### III. Historical Context

Alternate care is neither a new problem, nor a problem that is unique to the Rochester community. Studies show that this problem has persisted over time, and it has been reported in Canada, England and other countries.<sup>6</sup> Figure 1 illustrates the levels of alternate care in Monroe County from 1983 through November 2008. The data show that alternate care peaked in Monroe County hospitals in 1991. In the most recent period ALC has averaged to 50-55 patients.



**Figure 1**

Over the years an array of measures have been taken by the hospitals, payers, long term care providers and Finger Lakes Health Systems Agency (FLHSA) to reduce these inappropriate hospital stays. These measures have included but are not limited to:

- FLHSA and NYS requiring that nursing homes admit a “fair share of Medicaid patients as a condition of approval for any certificate of need application;
- Community organizations more than doubling the capacity of senior housing alternatives;
- NYS introducing Medicaid case mix reimbursement which linked the score of all patients in nursing homes to the Medicaid rate so that facilities were incented to admit high care patients rather than low care patients;
- Hospitals undertaking a variety of initiatives such as those reported by the University of Rochester Medical Center Hospitals (URMC) which include but are not limited to:

<sup>6</sup> FLHSA. “Task Force Report on The Hospital Back-Up of Long Term Care Patients.” November, 1979, p. 10.

- Incorporating ALC management objectives in the Board of Managers' Annual Plan with quarterly outcome measurement, resulting in the highest level concentration on the hospital's ability to manage the median length of stay per patient and save bed days;
- Creation and staffing of centralized placement offices;
- Creation and staffing of daily ALC management rounds;
- Daily contacts with local nursing facilities to determine bed availability;
- Creation of an Alternate Care Unit to optimize the delivery of appropriate care and focus discharge planning activities;
- Creation and staffing of financial case management program including a DHS liaison to focus activities associated with getting Medicaid eligibility determinations made in a timely manner;
- Creation of hospital based guardianship protocols to obtain expedited guardianship for individuals who require them prior to discharge;
- Development of the "Pathway Proposal" approved by NYSDOH that enables UPMC hospitals to provide non-patient specific support to nursing homes in order to enable them to better care for complex patient populations;
- Development of a behavioral care partnership with Shorewinds Nursing Facility, through which UPMC provides psychiatric consultation that enables facility staff to provide care for patients with complex behavioral considerations in the care plans;
- Expansion of interpreting services to respond to care and discharge planning requirements of patients who have limited English proficiency;
- Collaborative development of hospital teams with the Department of Human Services to create more efficient protocols for hospital care management representatives to work with Medicaid examiners to expedite determinations of Medicaid eligibility for hospitalized patients;
- Development of a partnership with experts in Social Security eligibility to facilitate Social Security Income (SSI) applications.

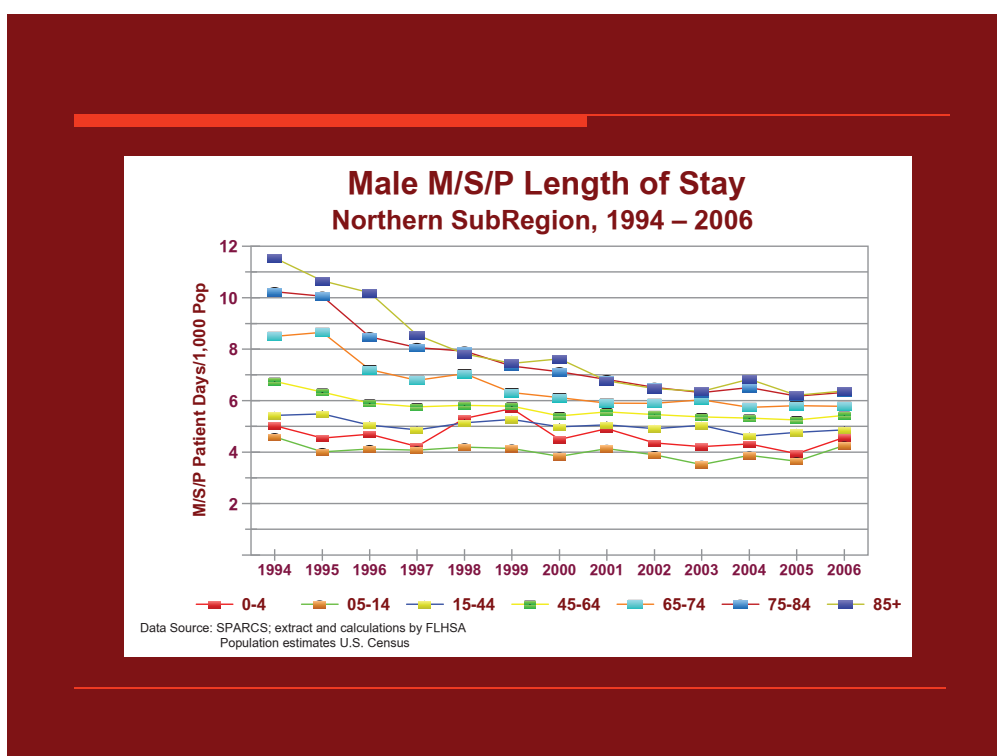
Community activities have included but are not limited to:

- Expanding the capacity of long term home health care programs, the PACE program, and hospice services;
- Expanding adult day health care and Certified Home Health Agencies (CHHA) service volumes;
- Developing demonstration projects such as the Visiting Nursing Services (VNS) and Genesee Region Home Care's "One Caring Place" and Park Ridge Hospital's geriatric medical surgical admission unit;
- Developing specialty beds in nursing homes for people who needed ventilator, dialysis, and behavioral care;

- Long term care providers hiring personnel to facilitate timely completion of Medicaid applications;
- Nursing homes increasing their emphasis on rehabilitation and increasing their discharge rates;
- People electing to use community services thereby preventing/delaying nursing home admissions, which reduced Skilled Nursing Facilities (SNF) lengths of stay and increased nursing home bed availability;

Appendix 3 provides more detailed information about these interventions and their timing.

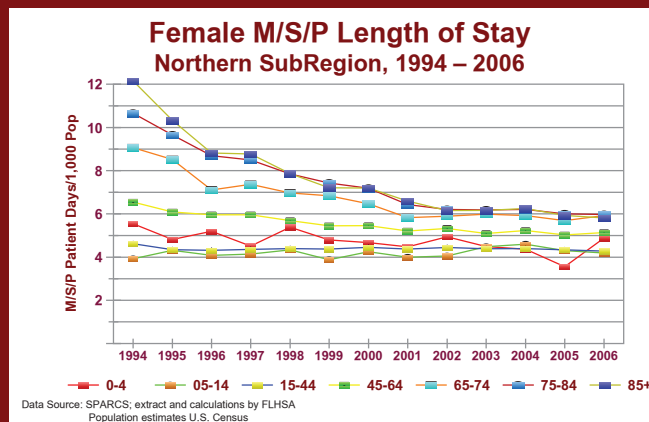
The result of these interventions is reflected in the decline in ALC. However, to appreciate the pressure on patients, families, and discharge planners, it is appropriate to note that these changes have been occurring while the overall hospital discharge rates have remained essentially stable<sup>7</sup> but lengths of stay have been declining. Figures 2 and 3 show that men and women over 75 have had the greatest reductions in their acute lengths of stays. Constant discharge rates and shorter stays mean that hospitals are responsible for safely discharging greater numbers of patients in shorter periods of time.



**Figure 2**

<sup>7</sup> SPARCS data extract FLHSA calculations 1994-2006.





**Figure 3**

#### **IV. Approach**

Once the decision was made to focus the study of gaps in services and barriers to accessing long term care on the alternate care population, the Care Management Workgroup of the Monroe County Long Term Care Council designed the survey tool and hospital discharge planners carried out the study. The survey instrument was administered on August 6, 2008 in all hospitals in Monroe County. (Appendix 4 contains a copy of the tool). All patients who met Medicare's Inter-Qual definition of an "alternate care patient" were reviewed and information was gathered by discharge planning staff. To insure patient confidentiality, names and other identifying data were not collected. Each hospital sent the completed survey tools to FLHSA. (FLHSA provides staff to the Monroe County Long Term Care Council.) The staff person aggregated and analyzed the data, and developed a draft of the report for the Council's consideration. The Council asked questions which led to modifications prior to the report being finalized.

Since FLHSA routinely receives weekly reports of the alternate care census from each of the hospitals, *the purpose of this survey was not to quantify ALC, but rather to profile the patients and determine their needs and barriers to their being discharged.*

It should be noted that all of the hospitals in Monroe County fully cooperated with the study. Their help was essential to this effort, and is greatly appreciated.

#### **V. Findings**

On the day of the survey there were 38 patients on alternate care status. While this was about 30% lower than the average ALC census this year, after reviewing an analysis of the patient characteristics, the discharge planning leadership at the hospitals told the Work group that the patients were representative of the types of patients they have been seeing.

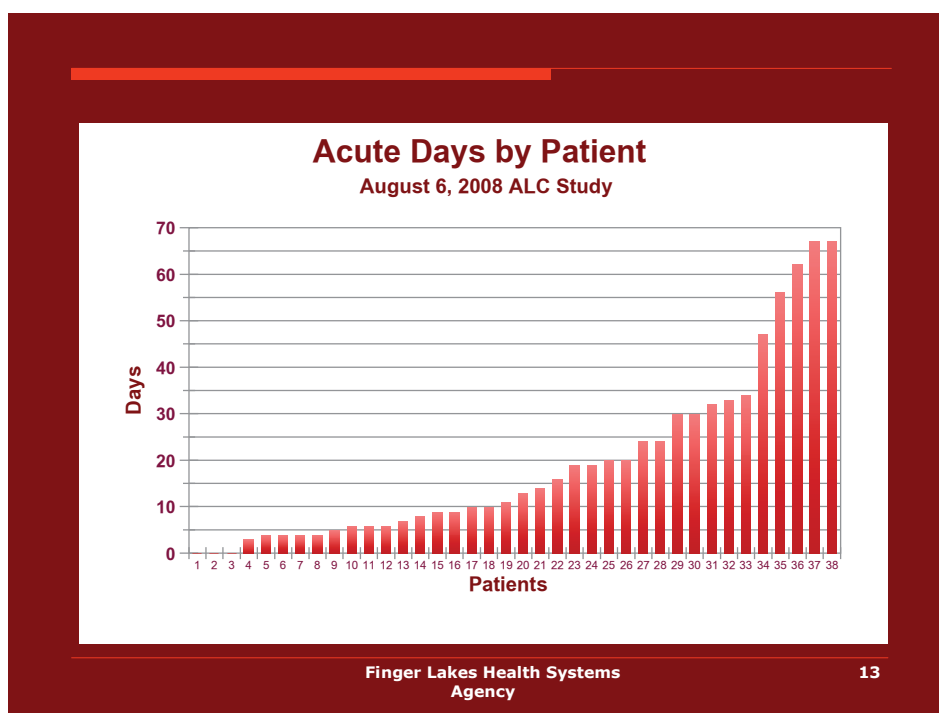
Moreover, the characteristics were remarkably consistent with a 2001 study done by the hospital social work directors group.<sup>8</sup>

## A. Resources Used

On the day of the study these 38 patients were found in 4 types of beds:

- 46% were on the alternate care unit at Highland Hospital; (this unit is used by Strong and Highland);
- 38.5% were in medical surgical beds;
- 10% were in psychiatric unit beds; and
- 5% were in an acute rehabilitation bed.

Together these patients had spent 733 days on acute care and 1221 days on alternate care status awaiting discharge. Since the average acute stay in a medical surgical bed in Monroe County is 5.8 days, 1221 alternate care days precluded approximately 190 acute med/surg. admissions.<sup>9</sup>

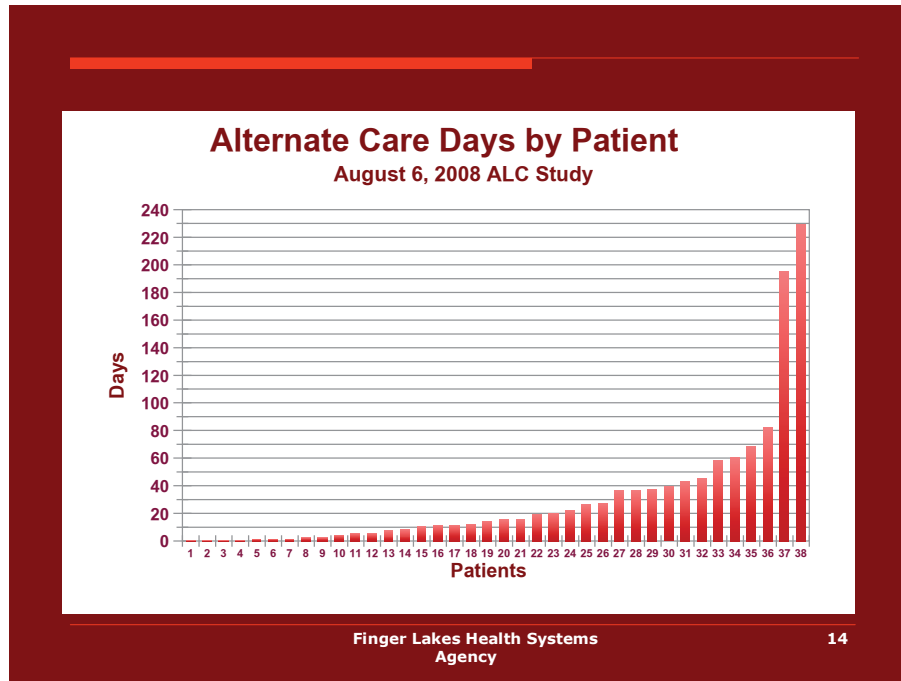


**Figure 4**

Figure 4 shows that three patients had no acute bed days. This means that they were admitted for social rather than medical reasons. The median acute stay was just over 10 days, while the average was 19 days per patient, due to the lengthy stays of some patients. Five patients had acute stays over 30 days in duration.

<sup>8</sup> Susan Saunders Report to the Community Transition Task Force: “Health Systems Analysis of Barrier Patient Days” July-December 2001.

<sup>9</sup> Source of Length of Stay: SPARCS, 2006. Calculation of admissions prevented assumes 90% med/surg occupancy.



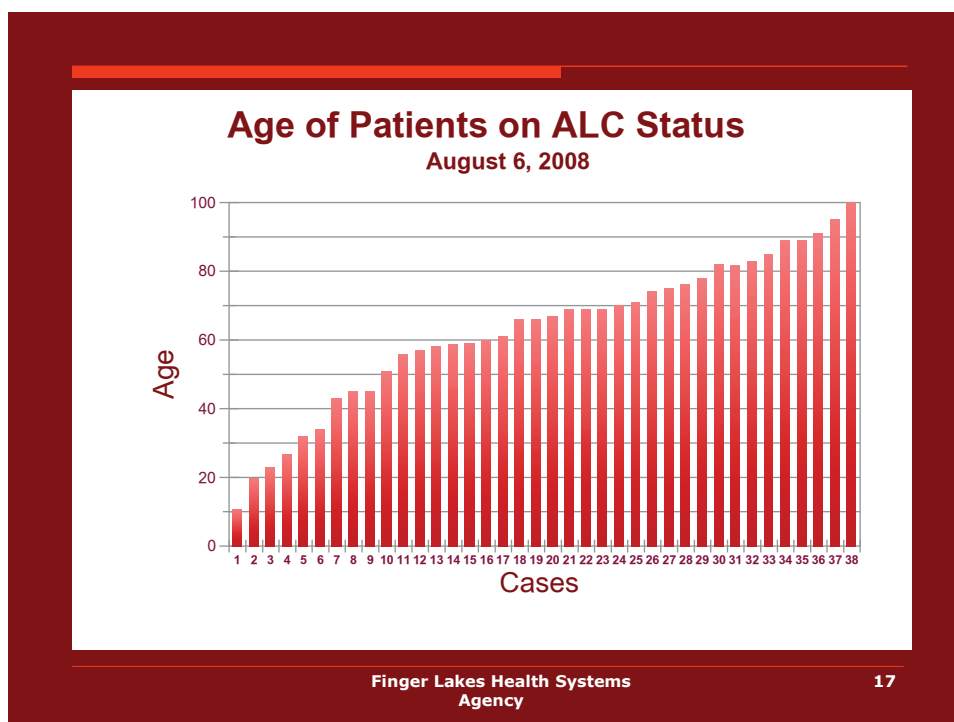
**Figure 5**

The data in Figure 5 indicate that the median ALC stay was 15 days. While nearly half of the patients accumulated fewer than 14 days on alternate care, the average stay was 32 days per person. The data reveal that 5% of the population accounted for 35% of the total ALC days.

## **B. Profile of the Patients**

### *1. Gender*

Sixty-three percent of those on alternate care were women, and 37% were men. These data are remarkable when compared to a nursing home population where 75% are usually women. (This comparison is made because later data will show that discharge planners reported that approximately 70% of the patients were expected to be discharged to a skilled nursing facility. See Figure 14)



**Figure 6**

## 2. Age

Figure 6 shows that the ALC patients on August 6<sup>th</sup> ranged from an 11 year old to a patient who was 100. Both the average and median age was 63. These data are remarkable because 45% of the patients are 60 years of age or younger. Only 25% of the patients were over 80. (The average age of nursing home patient is 83, and less than 14% are under 65 years of age.<sup>10</sup>)

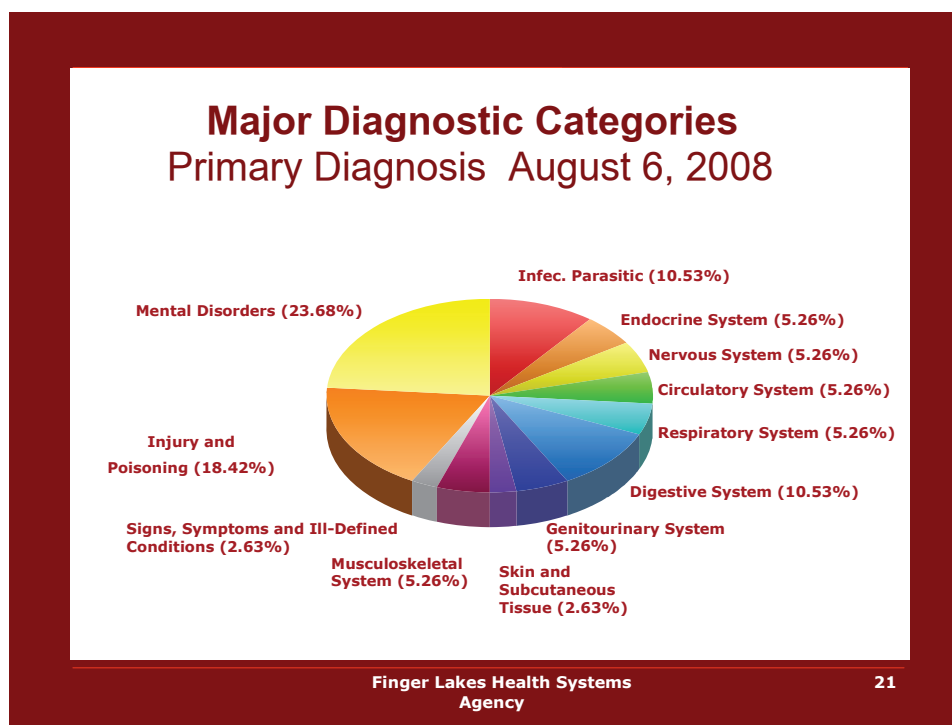
## 3. Race/Ethnicity

Black patients accounted for 18% of the population on Alternate Care. This is 3 times the proportion of Black people in the 65 and over population in Monroe County. White people accounted for 82% of the population. None of the patients were identified as Hispanic or had Spanish identified as their primary language.

## 4. Language

Two of the patients communicated in American Sign Language (ASL). While there was no attempt to assess the number of patients with other hearing deficits, none of the other patients had hearing identified as a barrier to discharge. Rochester has a relatively large deaf population. It is home to the Rochester School for the Deaf, the National Technical Institute for the Deaf at Rochester Institute of Technology and is a place where deaf people choose to live because it is considered a “deaf friendly city.”

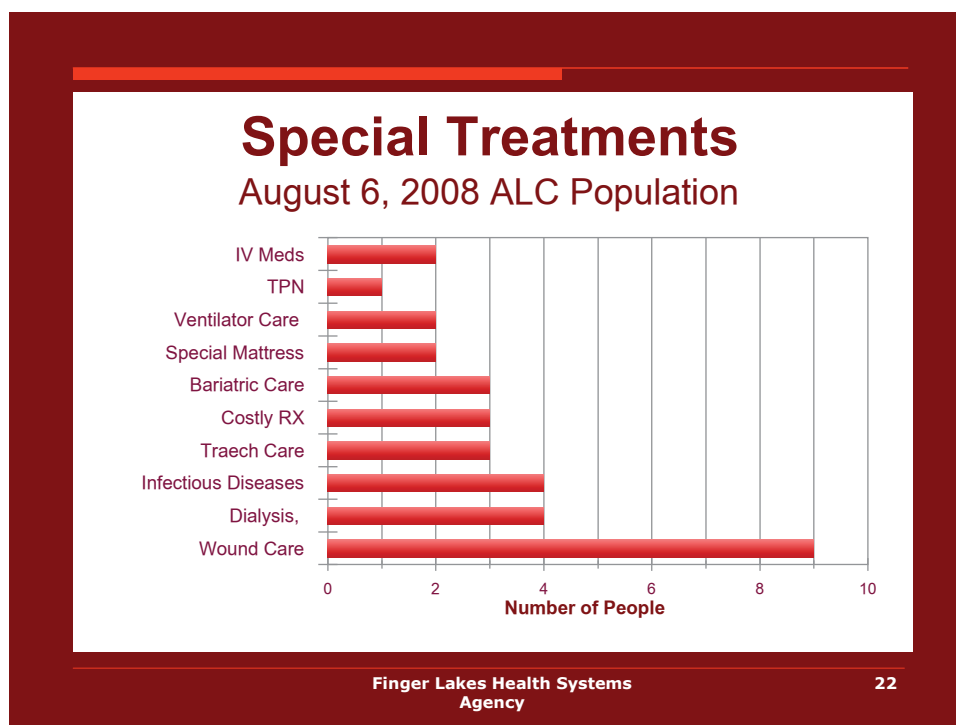
<sup>10</sup> Met Life Mature Market Institute in conjunction with Life Plans, Inc. “The Met Life Survey of Nursing Home and Assisted Living Costs.” October, 2008.



**Figure 7**

#### 5. Primary Diagnostic Categories

Figure 7 shows that while patients had illnesses across the spectrum of diagnostic categories, two categories were particularly prominent in this population. Mental disorders accounted for 24% of the patients, and injuries accounted for 18%. Two other categories infections and diseases of the digestive system each accounted for 11% of the patients. Data will be presented later which illustrates the difficulty addressing the special needs of patients in some of these diagnostic categories.

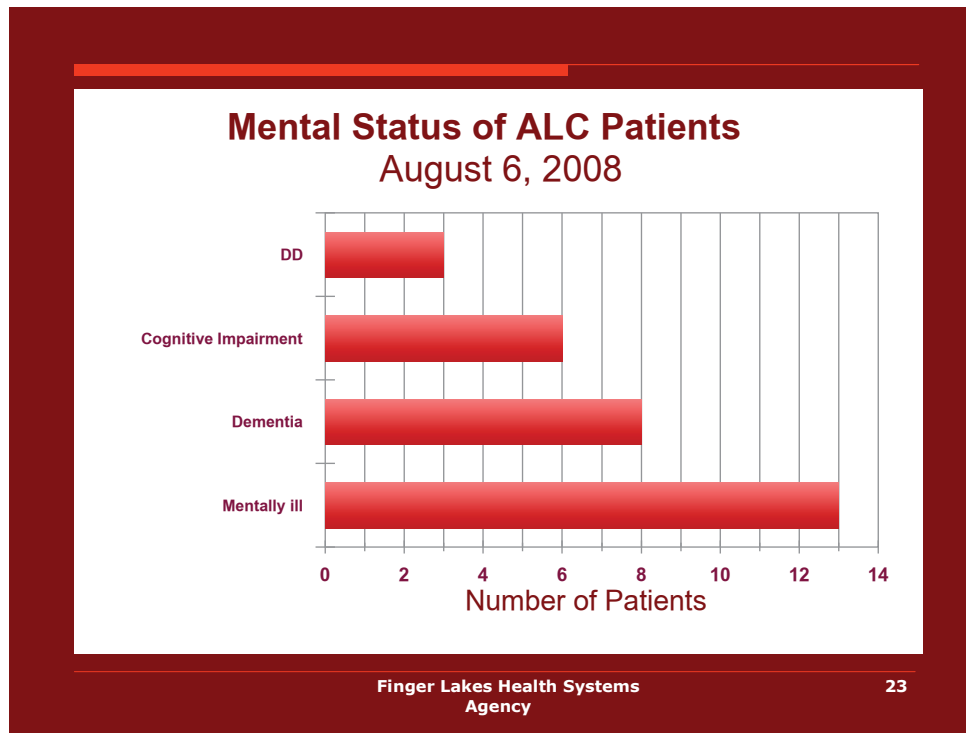


**Figure 8**

## 6. Special Treatment Needs

Discharging patients with special care needs requires additional time and special types of resources to assure they are discharged safely. Figure 8 shows that among the 38 people on alternate care status, there were 36 instances of special care needs (some patients had more than one special need.) Nearly a quarter of the patients (24%) required wound care.

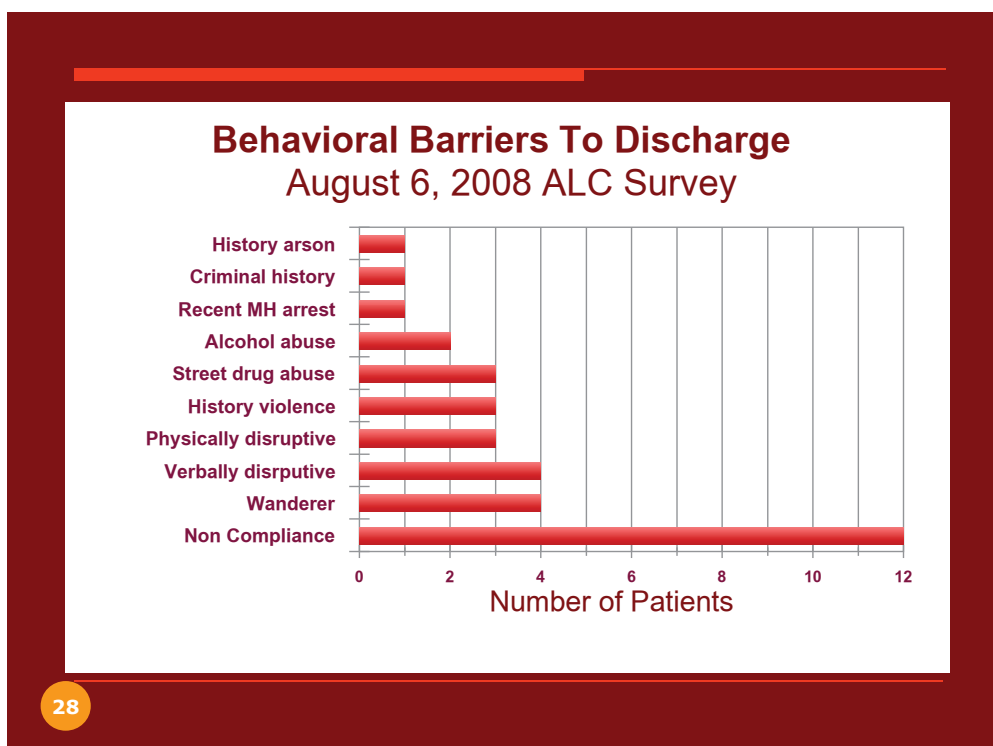
Ten different types of special care needs were identified. Some patients are clinically complex; some require special equipment such as dialysis machines, ventilators, or specially sized equipment for obese patients. Many of these types of care require greater resources and thus incur higher costs than the average home care or nursing home patient. For example, pharmaceutical expenses can range as high as \$10,000 a month, which can make the patient cost-prohibitive to long term care providers.



**Figure 9**

### *7. Mental Status*

This study found that over a third of the ALC patients had a mental illness. The study also revealed that 21% had dementia, 8% were developmentally disabled, and 16% were cognitively impaired for other reasons. Because many of those involved in the study were familiar with the behavioral barriers to discharging patients on ALC status, the survey asked for specific information about the types of behaviors which made discharge planning challenging.



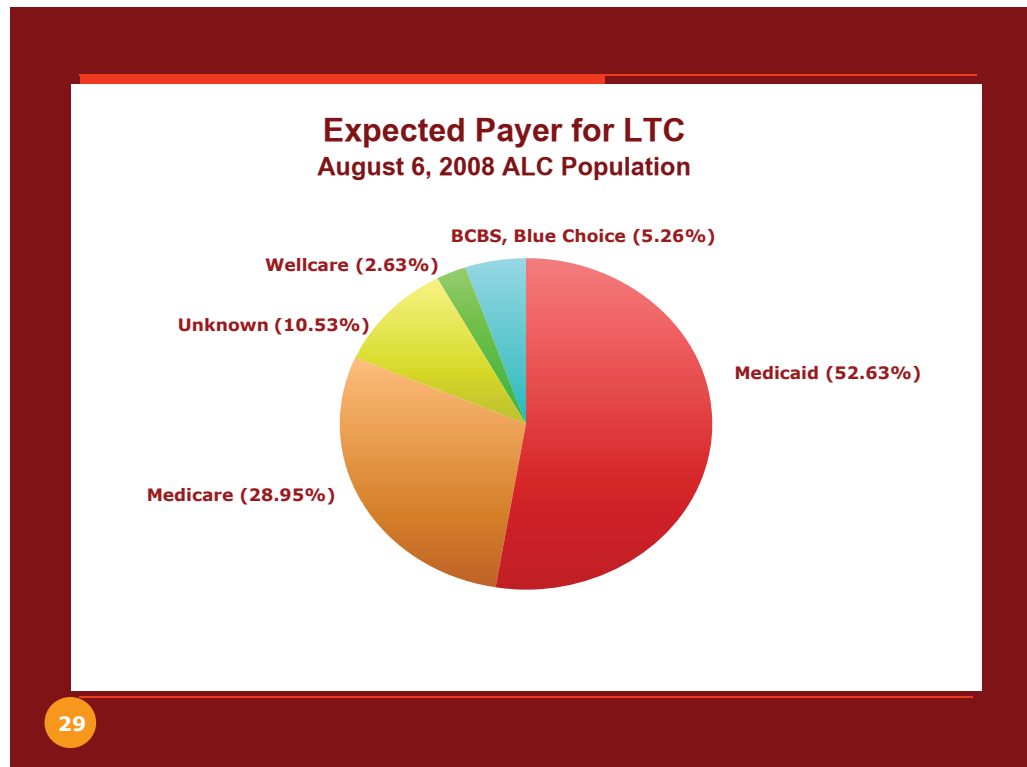
**Figure 10**

#### 8. Behaviors that Delay Discharge

Figure 10 indicates that over 30% of the ALC patients had been identified as historically non-compliant with their care plans. Non-compliance can mean many things, and a limitation of the current study was that “non-compliance” was not defined more specifically. Still, it should be noted that failure to comply with a plan of care can be a cause for a family member to discontinue being a care giver, or a formal long term care provider refusing to readmit a patient to care.

What is striking on the list of behavioral barriers to discharge is the number of patients who have histories of violent behaviors. Finding appropriate care for violent patients and patients who have substance abuse considerations in their care plans present major challenges to discharge planners. This is because historically health care services in New York State have been planned, regulated and reimbursed in multiple silos which failed to take into account that people have care needs that cross health, mental health, developmental disabilities, alcohol and substance abuse categories. While the current philosophy is to embrace “patient centered” care planning, the service systems have not yet caught up with the patients’ complex needs. Further evidence of the challenges to serving these patients adequately is the lack of a comprehensive assessment tool that assesses patient needs across all these domains.

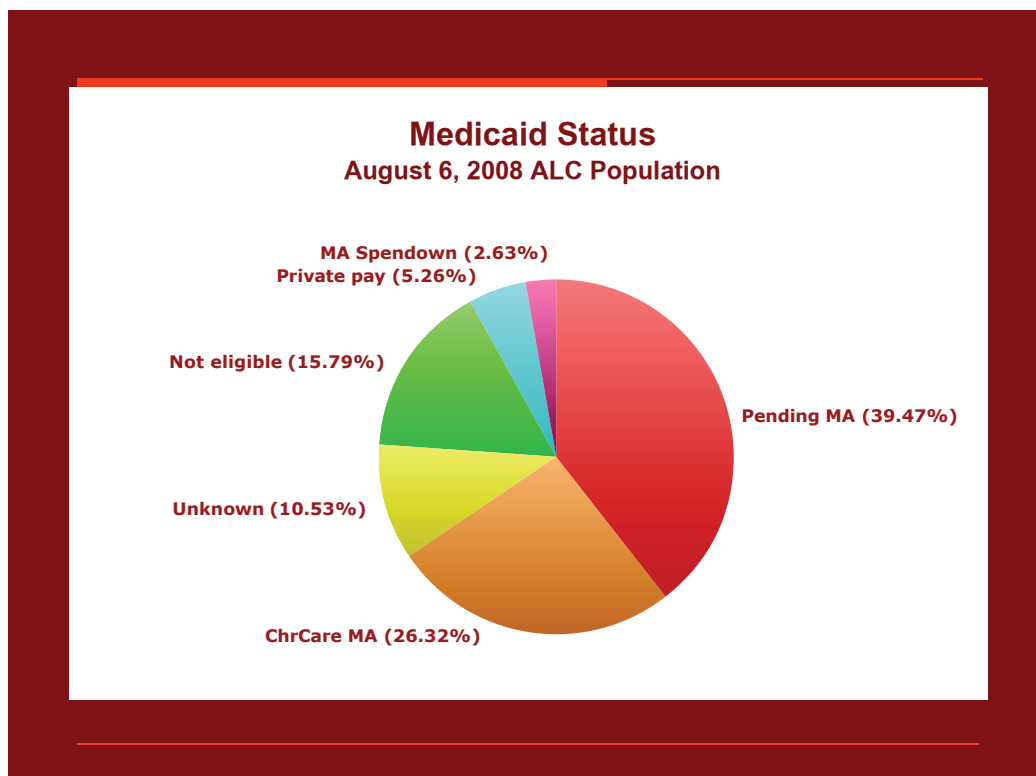




**Figure 11**

*9. Expected Payer for Long Term Care*

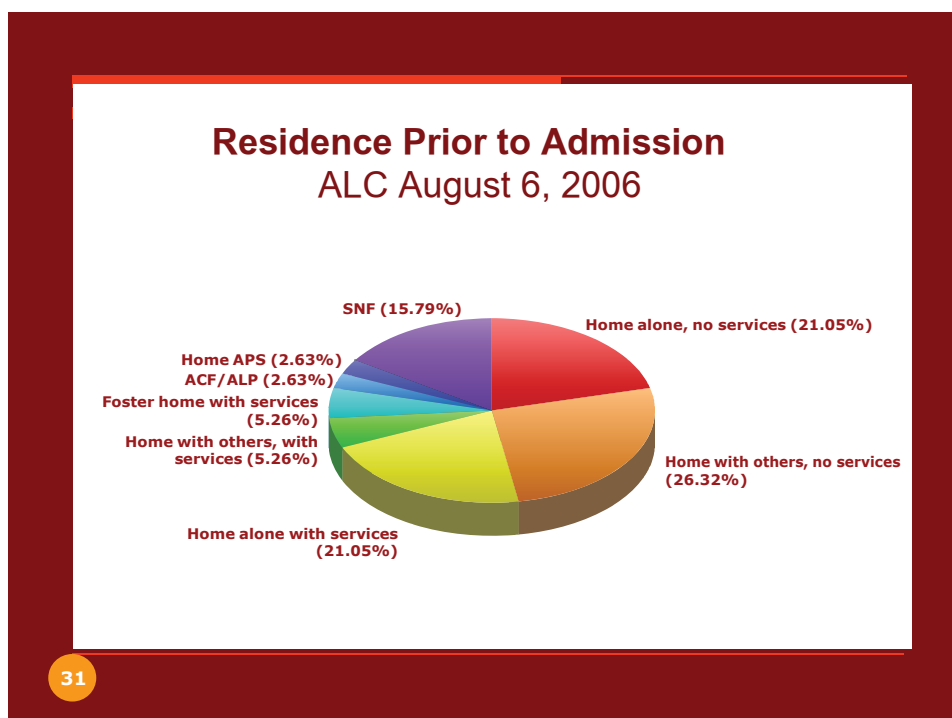
Over half of those on alternate care status are expected to have Medicaid as their payer for long term care services. Since Medicare pays for rehabilitation, but not long term care, the estimated 29% being covered by Medicare may not be realistic. As Figure 11 data show, a very small percentage of people can expect to have private insurance pay for their long term care needs. It is quite possible that at least 75% of the population will rely on Medicaid to pay for their long term care.



**Figure 12**

#### *10. Current Medicaid Status*

Because Medicaid is the dominant payer of long term care, the survey determined the ALC patients' current Medicaid status. The data in Figure 12 show that 26% of the patients had chronic care Medicaid established. Approximately 3% would be eligible for chronic care Medicaid after spending down. A revealing fact is that 40% had a Medicaid application in progress, but there had not been a determination of eligibility. The number of patients with Medicaid pending is significant because some long term care providers will not accept a patient prior to a source of payment being established.



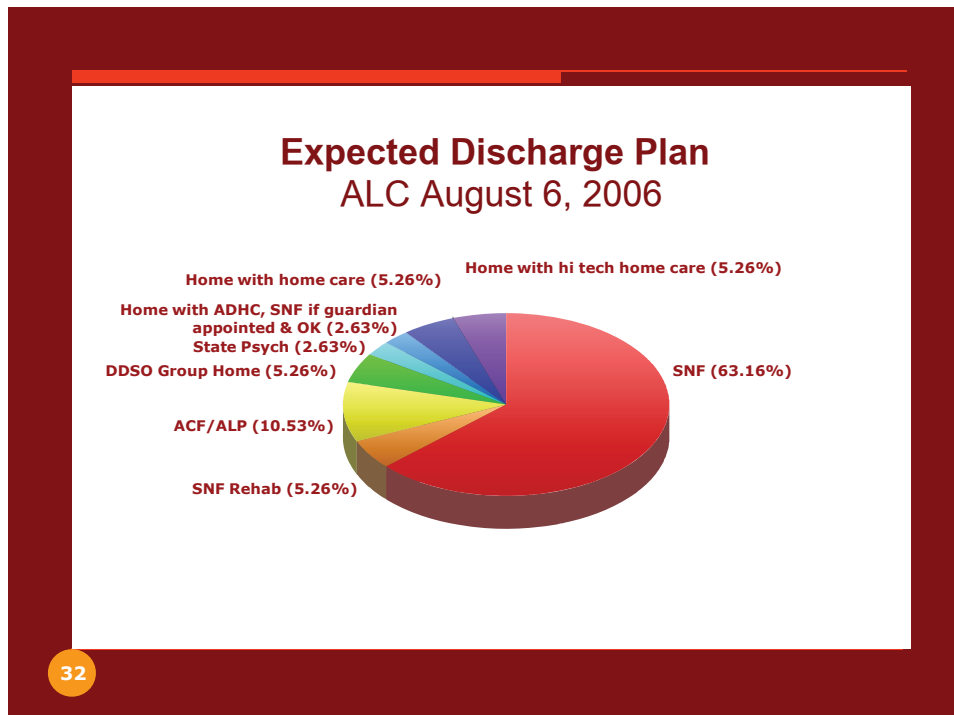
**Figure 13**

#### *11. Residence Prior to Admission*

Prior to being admitted to a hospital, nearly 80% of the people on ALC had been living in the community without the support of residential services. Figure 13 shows that over 65% were living at home. Not only were they living at home, nearly half of the ALC population had no formal support services recorded prior to their admission. It is possible that some individuals would have been eligible for home and community based services but did not access them.

Without an electronic communication system between hospitals and community based services providers, it has not been possible for emergency room and hospital discharge planners to have timely information on whether patients received home care or other community based services prior to their hospital admission.

Given the prevalence of patients with behavioral considerations in their care plans, a further analysis was done to the prior residence of those patients. While the sample is small, it appears that those with non-compliant behavior had a greater likelihood of coming from a facility (1.4 odds ratio) or from home without services (1.4 odds ratio), than living with others (0.6 odds ratio) or coming from home with services (0.5 odds ratio).



**Figure 14**

### *12. Expected Discharge Plan*

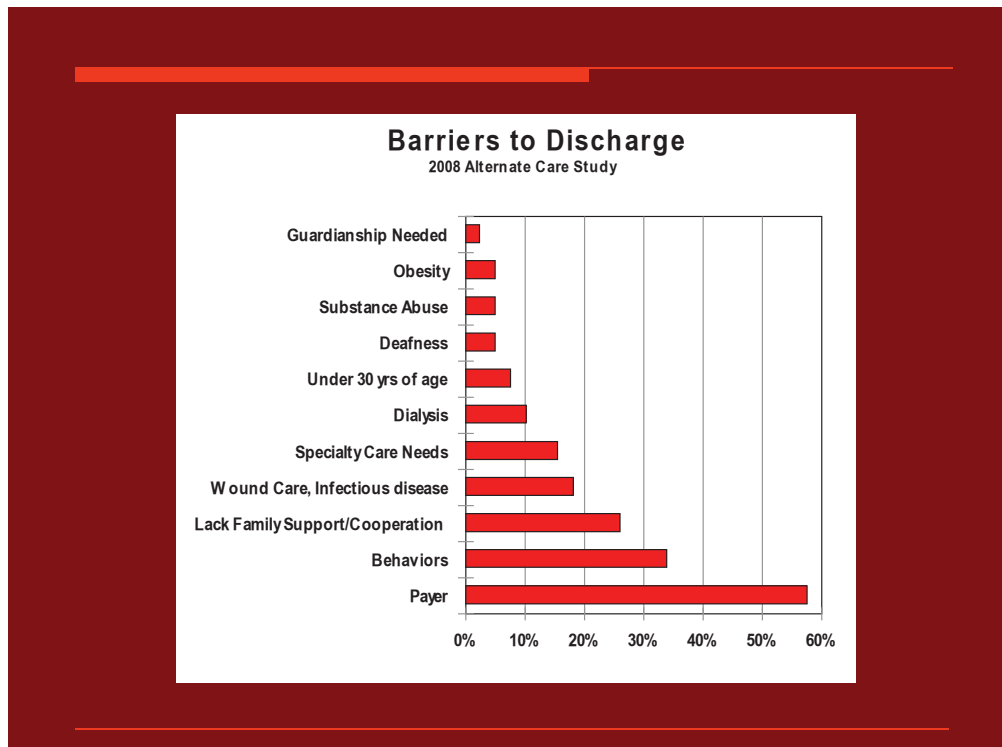
Given the high percentage of people who were living at home prior to their admission, it is important to note that discharge planners indicated that they expected 68% of the ALC patients to require a skilled nursing facility at discharge. (See Figure 14) A limitation of this one day point prevalence study is that it does not provide the actual discharge disposition for these patients. Some of the reasons for the expected change in patients' post-discharge site of care are found in the identified barriers to their discharge.

### **C. Barriers to Discharge**

Barriers to discharge were identified in three ways:

1. Discharge planners were asked to identify what they perceived to be the primary barriers to the patients being discharged.
2. A specific question was asked to identify specific behaviors that were perceived to be a barrier to discharge.
3. Cases were split into quartiles by their length of alternate care stay, and analyzed to determine if there were any variables which increased by quartile.

Figure 15 identifies what discharge planners perceived to be the barriers to discharge. Not having an established payer for long term care services was perceived to be a barrier for nearly 60% of the patients. Having behavioral considerations in the patient's care plan was reported to be affecting over a third of the population. A family's inability or unwillingness to participate in care was the third most frequently cited barrier to discharge. Specific types of clinically complex care and age were the other issues that were identified.



**Figure 15**

Figure 10 (see page 14) identifies the specific behaviors that were barriers to discharge. The primary behavior that was reported as a barrier to discharge was a patient's prior history of failing to comply with the treatment plan. The other types of behavior that were reported to interfere in discharge were activities which had the potential for violence or destructive outcomes.

When the profile data were split into four groups by the patients' lengths of alternate care stay, there were several variables that increased with each quartile split. Figure 16 simply ranks these from highest to lowest.<sup>11</sup> The quartile splits indicate that being male or needing specialty services contributed most to ALC stays. Given the small sample size, no conclusive statistical inference can be made from these observations, but they should be monitored over time.



**Figure 16**

#### **D. Discussion**

While there are some differences depending upon how barriers to discharge were identified, there are some underlying similarities. First, men are more difficult to discharge to a long term care facility because many facilities have double rooms and the ratio of women to men in nursing homes is typically 3 to 1.

Needing specialty care is identified in Figures 15 and 16. In cases such as dialysis and ventilator beds, capacity can only be increased with certificate of need applications. Other types of specialty care typically require higher levels of staffing, possibly special equipment, high cost medication, and often extra supplies. The resources required to provide such care may cost more than long term care providers are reimbursed.

Having an infectious disease or needing wound care, were factors identified in Figures 15 and 16. Both may require care in a single room as well as more intensive resources (wound vac, supplies, and IV medications).

<sup>11</sup> Note: Because the sample was small and multiple variables contribute to delays for most patients, statistical analysis would not be meaningful.

Not being Medicaid eligible or not having a payer has been identified as a cause of local alternate care since at least 1979.<sup>12</sup> Long term care providers state that they cannot afford to admit a patient who does not have an established payer. Because long term care services are expensive, many people must apply for chronic care Medicaid to pay for the care which they require. The application requires proof of a person's assets, income, and property, including any resources which they may have been given away over the past 5 years. Assembling the required information, completing the application, and having it processed by the county take time. While hospitals and long term care providers have hired specialists to assist patients complete the applications, patients can still linger in hospitals waiting for the application to be completed and an eligibility determination made.

In some cases the family frustrates, rather than helps, the process of gathering the required documents. In other cases there may be no family to assist. In the most difficult cases guardianship for both personal and financial decision making needs to be established. The process for guardianship can take more than 3 months to complete.<sup>13</sup>

As the data indicate, a significant percentage of the population has behavioral considerations in their care plans. Long term care providers are prepared to care for older adults with dementia. Recent ALC studies are finding, however, that working age adults have skilled nursing needs for both physical problems and behavioral issues due to mental illness, cognitive damage, developmental disability, substance abuse or combinations of these disabilities.

Care planning for people who are multiply impaired is a challenge for several reasons. When a person's health needs cross the lines of responsibility of multiple state departments/agencies, programs, regulations, and reimbursement do not provide adequate guidance and resources to meet the person's needs. One of the most glaring aspects of the lack of integration across state agencies is evidenced by the lack of a holistic assessment tool which allows consistent assessment of people's physical status, mental health status, cognitive status, and substance abuse history. When FLHSA identified the needs of multiply impaired geriatric patients as part of its 1993 Skilled Nursing Plan, the recommended regulations and reimbursement were not developed by NYS Health Department, even though the Plan itself was accepted by the State Hospital Review and Planning Council.

## **E. Recommendations**

One of the first problems which were identified was by the Care Management Workgroup that patients in crisis are being sent to emergency rooms with little or no information about their social history, their payer status or their historic use of community based services.

- 1. To enhance communication between hospitals and community based service providers, Monroe County Long Term Care Council recommends that each of the major hospitals in Monroe County, specifically their Emergency Department and Social Work/Care Management Departments, become linked to Peer Place.*

The Regional Health Information Organization (RHIO) has \$12M to develop an extensive electronic information system that will link primary care providers with hospitals in order to share clinical information in real time. This system is now developing the capability to link emergency medical service providers to hospitals during care transitions. This will not only

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<sup>12</sup> FLHSA. Ibid.

<sup>13</sup> Robert Swidler, Esq. "Using Guardianship to Accomplish a Hospital Discharge". Power point Presentation.

permit transmission of clinical data, but will also allow transmission of Medical Orders for Life Sustaining Treatment (MOLST) and advanced directive plans.

The Monroe County Long Term Care Council recommends that Peer Place, an electronic information exchange funded by the Monroe County Office for Aging, be linked to the hospitals to facilitate timely exchange of information critical to discharge planning.

As a result of conversations with the Director of the Monroe County Office for Aging and members of Monroe County Long Term Care Council who are part of the RHIO Advisory Committee, RHIO has paid for Peer Place to develop an electronic bridge so that information regarding community based services funded by the Monroe County Office for Aging can also be accessible to hospital emergency room and discharge planning staff to facilitate timely consideration of patients' pre-existing care partners in developing discharge plans.

2. *To improve continuity of care and best practice the MCLTCC recommends that third party payers recognize the value of transitional care specialists, and reimburse this cost*

There is an increasing body of research which demonstrates that patients are most at risk for being destabilized when transitioning from one site of care to another.<sup>14</sup> Transitional Care encompasses a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care and across care settings.<sup>15</sup>

Emerging evidence suggests that high-quality transitional care is especially important for people with chronic conditions and complex therapeutic regimens, as these patients typically receive care from multiple providers and also experience frequent transfers within healthcare settings. Poor “handoff” of these patients and their family caregivers from hospital to home has been linked to adverse events<sup>16</sup>, low satisfaction with care<sup>17</sup> and high re-hospitalization rates.<sup>18</sup>

Many factors contribute to gaps in care during critical transitions, including: poor communication, incomplete transfer of information, inadequate education of patient and caregiver, limited access to essential services, and the absence of a single point person to ensure continuity of care. Language, health literacy issues and cultural differences exacerbate the problem.<sup>19</sup>

Nurse-led interdisciplinary interventions have consistently improved quality and result in cost savings.<sup>20</sup> Studies indicate that adverse events, medically related complications and hospital readmissions are reduced by using nurse practitioners or physician assistants to shepherd patients through transitions. This assistance has also been shown to enhance patient understanding and adherence to the plan to care.

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14 [www.commonwealthfund.org/spotlights/spotlights\\_show.htm?doc\\_id=430025](http://www.commonwealthfund.org/spotlights/spotlights_show.htm?doc_id=430025) Coleman, Eric., MD “Improving Care Transitions.” Health Policy, Health Reform, and Performance Improvement. 2004.

15 Coleman & Boulton, 2003; Naylor, 2003

16 Forster et al., 2003; Moore et al., 2003; Wenger & Young, 2007),

17 Harrison et al., 2002; Levine, 1998; Weaver et al., 1998

18 Bernstein et al., 2004; Naylor, 2003; Vinson et al., 1990

19 (Naylor, 2003)

20 Coleman et al., 2004b, 2006; Naylor et al., 1999, 2004; Rich et al., 1995).



Adherence to the care plan is improved when patients and caregivers receive culturally sensitive and health literacy appropriate education and support in developing a plan that is workable in their daily life (i.e. consistent with their personal goals and life circumstances). Currently there are not mechanisms to pay for this type of education and transitional care support. It should be noted that both Western and Central NY are embarking on Transitional Care programs. It is recommended that Rochester also provide this type of care.

3. *To improve comprehensive patient assessments and holistic care planning, MCLTCC recommends that there is need for a uniform assessment tool that can be used to assess patients' needs across multiple domains.*

If this community is to develop a patient centered approach to care, it needs to have assessment tools that provide holistic assessments of people's care needs. A uniform comprehensive assessment tool would allow agencies to have more consistent and reliable information about patients across the full spectrum of their assets and care requirements. Historically organizations have used tools based on the requirements of state and federal agencies which regulate and reimburse the patients care. However, as evidence in this study shows, the people who are most at risk of experiencing barriers to accessing the right care in a timely way are people whose needs transcend multiple service delivery and financing systems.

MCLTCC believes that this recommendation is both necessary and timely. Unity Health System is currently participating in a federal Centers for Medicare and Medicaid Services (CMS) study which is piloting a common assessment tool which could be used by hospitals, home care agencies, and nursing homes. NYS Home Care Association and the NYS Nurses Association are supportive of a common tool. NYS also has an interest in such a tool to help assure comparability of assessment, care planning, and reimbursement across health, social services and mental hygiene service providers. Moreover, as the community is working on development of the RHIO, it will be increasingly important that we have common electronic forms to facilitate inter-agency information transfer. Even though local attempts to develop such a tool were tried unsuccessfully about 15 years ago, it appears that the time may be right to try again.

The Council recognizes that while there may value in such efforts, the implications for such an undertaking transcend the local community because state and federal agencies require their existing forms for an array of purposes including: assessment, reimbursement, and quality assurance. To implement this recommendation will require a state and federal strategy.

The Council is aware that a Uniform Transition of Care Tool has been proposed Downstate, and this region should collaborate in efforts to develop such a tool in order that it would have statewide applicability.

4. *To Reduce Delays in Discharge due to Lengthy Medicaid Processes*

To assure that patients receive the right care, at the right time, in the most appropriate place, the MCLTCC recommends that delays in discharge be reduced by addressing several major problems.

- a. *To reduce delays in completing Medicaid application process and Medicaid eligibility determinations:* engage a 6 Sigma consultant with lean training to work with representatives of hospitals, County Social Services, and relevant

community and Long Term Care (LTC) service providers to identify sources of delays in completing and processing Medicaid applications.

- b. *To ensure that when sources of delays are identified, recommendations to address the delays will be implemented, the Council recommends that there be an explicit expectation that when organizations come together to work with the 6 Sigma consultant, the organizations demonstrate their commitment to carrying out recommended procedural changes by providing high level staff who have knowledge about procedures and policies that affect all aspects of the Medicaid processes for people served by their organization. The assigned personnel should be able to describe the current activities associated with the Medicaid process that occur within their organization, and have their organization's authority to commit to accepting the consultant's recommendations for system improvement.*
  - c. *To encourage long term care providers to accept patients prior to their having an established payer, the Council recommends that the County enter into discussions with the State and LTC providers to seek agreement on a method to routinely grant presumptive Medicaid for people in urgent need of LTC services, after applicants for chronic care Medicaid have been screened and adjudged eligible by experienced screeners (to be defined.)*
5. *To reduce delays in establishing Guardianship, the MCLTCC recommends that Monroe County LTC Council sponsor a presentation by Robert N. Swidler, General Counsel from Northeast Health System, Albany, NY. Attorney Swidler has proposed an alternative model which would use a three person Transfer Authorization Panel to move a person who requires a guardian to an appropriate long term care setting from whence permanent guardianship may be established.*

The rationale for such an approach is that remaining in hospitals beyond the need for acute care puts the health of patients in jeopardy. Moreover, a bed used for an alternate care patient, reduces the capacity of the acute care system to respond to the needs of people who require hospitalization. Finally, ALC stays incur inappropriate costs for third party payers.

In order to assess the feasibility of the Swidler proposal, it is also recommended that the presentation be part of a half day seminar which might be co-sponsored by Monroe County, the County Medical Society, the Monroe County Bar Association, the State Supreme Court, Eldersource, Lifespan, Catholic Family Center, hospitals in Monroe County, and the local nursing home associations. The intent of such a seminar would be to allow all of the relevant parties hear Mr. Swidler's proposal, and provide a local reactor panel to lead a discussion of the potential and limitations of such an approach. If it is considered feasible, it is recommended that a work group composed of representatives of the relevant organizations develop an approach which might be implemented locally on a trial basis. If it is not considered feasible, the meeting should produce a set of specific recommendations for the Law Revision Commission of NYS.

## 6. To Improve Access to LTC Services for People with Specific Needs

The Alternate Care Study documented that there are certain patient populations which are difficult to place, as evidenced by their length of stay on alternate care status. *MCLTCC recommends that:*

- a. *the number of single rooms in nursing homes be increased in order to allow more timely transfer of male patients and patients who require single rooms because of infectious diseases;*
- b. *FLHSA reassess the reliability of current need estimates for dialysis capacity for older adults. Part of this analysis should take into account the extent to which dialysis machines in skilled nursing facilities are available for the use of patients needing dialysis admitted to those facilities. The goal should be to have sufficient strategically located dialysis machines in nursing homes so that patients in need of both skilled residential care and dialysis would rarely need transport outside of a SNF for this treatment.*
- c. *the number of beds for bariatric (obese) patients be increased; and*
- d. *the need for additional beds for patients who require chronic ventilator care be monitored by FLHSA.*
- e. *NYS Health Department spearhead a process to develop best practice guidelines for screening and treating people who develop Methicillen Resistant Staphylococcus Aureus (MRSA) and Oxacillen Resistant Aureus (ORSA) infections. A common community approach is needed for the prevention, treatment, management and transfer of residents with MRSA and ORSA.*
- f. *Physicians work with FLHSA and Monroe County Department of Health to coordinate a study to identify the current prevalence of these infections across various levels and sites of care.*
- g. *When developed the best practice guidelines should then be used to educate care providers across the community, and an evaluation should be conducted to assess improvement in: reducing infection rates the appropriateness of screening, treating, and reducing resources required to address patients with these infections.*

## 7. To Address the Needs of Patients who require Specialty Care

Long term care providers are reluctant to admit patients whose cost of care is expected to exceed their rate of reimbursement. To address the needs of these populations, *MCLTCC will invite a Syracuse group to Rochester for a half day conference to share their experience with a transitional care and sub-acute models which they developed to enable patients to move from hospitals to long term care settings in a more timely way by creating a pool of funds to reimburse long term care providers for the “aggregate of community service they provide.”*

In order to test the feasibility of such a program in this community, *MCLTCC recommends that this half day conference be co-sponsored by local long term care provider organizations, local hospitals, and Monroe County.* It is suggested that after a presentation of the model, a reactor panel representing the various sectors give their initial response to the question of local feasibility. If it is thought to be feasible, *it is recommended that representatives from the various stakeholders form a workgroup to propose a local implementation plan.*

8. *To Address the Needs of Patients who Require both Skilled Nursing and Mental Health, Substance Abuse and/ or Developmental Disability Services, (in addition to the development of a unified assessment tool discussed in recommendation 3) MCLTCC recommends that NYS Departments of Health and Mental Hygiene use the data from this and other studies to validate the need for long term care settings that are licensed and reimbursed to address the needs of patients who are multiply impaired with needs that cross the spectrum of services which come under the departments of health, mental health, substance abuse, and developmental disabilities.*

The Workgroup commends Excellus's Long Term Care Behavior Health work group which has sought to expand the regulations and reimbursement which currently apply to neurobehavioral units. In order to prevent mixed messages on this subject coming from this region, MCLTCC sought and was granted representation on the Excellus workgroup to address the needs of these populations.

9. *To prevent unnecessary use of the emergency room and hospital alternate care days MCLTCC recommends that this community become more knowledgeable about and utilize all of the Home and Community Based Waiver programs to stabilize at risk people who reside in the community with enhanced resources that have the potential to prevent care plan disintegration and care giver burnout.*

*The Council also recommends that NYS take a person centered approach, and eliminate duplication of administrative structures to administer home and community based waiver programs.*

Organizations which are authorized to operate waiver programs should be able to determine the patient's needs and eligibility for any waived service and develop a care plan that best addresses the person's needs from the full array of services available.

10. *To address the needs of those who communicate with American Sign Language the Council recommends that one of the local skilled nursing facilities develop the capacity to provide a "deaf friendly" care environment.*
  - a. *One of the Long Term Home Health Care Programs (LTHHCP)s tried to provide services to the deaf population but was not able to continue because the cost of interpreters became prohibitive, it is recommended that third party payers make rate adjustments for patients that need both community based and institutional long term care services in order that patients are not isolated by their inability to communicate and that the cost of interpreting services (currently about \$62 per hour per interpreter), are not a barrier to providers admitting deaf patients to care.*

- b. To assess the extent to which other languages present a barrier to discharge, MCCLTCC will work with LTC providers to determine whether there are other populations in need of LTC services for whom language or culture are barriers to their receiving the right level of care in a timely manner.
11. *To make the best use of Geriatric specialists, MCLTCC recommends that FLHSA's Sage Commission identify geriatric specialists of all professions, (including professionals with geriatric expertise), identify all of the current geriatric interdisciplinary teams which exist, and assess the best ways to deploy and utilize these resources to meet the needs of adults with multiple co-morbidities and fragility.*

## **F. Current Community Initiatives**

The staff consultant to this project is also responsible for certificate of need review for Finger Lakes Health Systems Agency. Since it is the policy of FLHSA to condition approval of any new skilled nursing beds, or renovation/replacement of existing beds on their addressing the needs of alternate care patients, FLHSA took the following actions in 2008 to address the needs of the ALC population:

- a. Supported renovation of existing areas of Monroe Community Hospital for 49 single rooms;
- b. Recommended approval for Monroe Community Hospital to add 12 dialysis stations;
- c. Recommended replacement of Park Ridge Nursing Homes with four duplex cottages of 20 beds each (80 single rooms) and a 40 bed short stay SNF rehabilitation unit; One floor will provide comprehensive rehabilitation, 48-hour post-operative care, *wound care management, and IV antibiotic care for short stay residents. The entire facility will accept patients who: have Methicillen Resistant Staphylococcus Aureus (MRSA) and Oxacillen Resistant Aureus (ORSA) infections, require the use of wound vacs, Clinitron beds, or are obese.* The facility will also provide care for patients requiring Peripherally Inserted Central Catheters (*PICC*) lines and enteral feeding, as well as care for patients with dementia. The facility will *accept patients who are awaiting Medicaid approval and those who are in the process of having guardianship established.*
- d. Recommended replacement of Crest Manor with a new facility of 80 single rooms which will *expand the facility's flexibility to accept more male patients, more patients who require infection control protocols while providing a more soothing environment for people with dementia.*
- e. Recommended replacement of 20 skilled nursing beds at St. John's Home with 2 Green Houses of 10 beds each. This *will add another 20 single rooms.* The analysis indicated that it would be desirable for St. John's Home to equip one of the Henrietta Green Houses to serve deaf people who use American Sign Language (ASL).
- f. Several of the SNF renovations approved this year by FLHSA staff, included a *contingency that the facility increase admissions of people of color to a level equivalent to the percentage of people of color 85 and over in the 2000 census;*



## **G. Limitations of This Study**

A major limitation of this study is that the results are based on a one day point prevalence study, and there were only 38 patients in the sample. As indicated in the report, FLHSA routinely receives ALC numbers from the hospitals. Those data, found in figure 1, provide a more accurate quantification ALC in Monroe County over time.

The intent of this study was not to quantify the problem, but rather to use a convenience sample of ALC patients to describe the gaps in services for those who are elderly or chronically ill and the barriers to their accessing care. When the profile data were presented to the Care Management Work Group, administrative level personnel from the three largest hospitals in the community indicated that the population found on the day of this study was representative of the types of patients which they have been routinely seeing. The one difference that was observed was that the cohort of people on the day of this study did not include people whose primary spoken language is not English. Discharge planners indicated that language can be another barrier to timely discharge.

When the characteristics of this population were compared to the characteristics of ALC patients found in past studies the data reveal similarities across time.

This type of study is not a time and motion study, and therefore does not have the ability to capture and describe days that are lost in the multiple processes that are required to assure that patients are safely discharged to the most appropriate site of care. However, because patients dependent on Medicaid to pay for post-hospital services have been a recurrent finding of ALC studies in this community since 1977, a recommendation from this study is that a 6 Sigma process be used to review the Medicaid application process and eligibility determination processes as these processes potentially delay access to the long term care system.

As stated earlier in the report, the cohort was too small to attempt to attribute causality to the various factors that contribute to ALC. A much larger sample might allow statistical tests to determine the extent to which the various factors contribute to patients' length of alternate care stays. Absent such capacity, the analyst did split the population into quartiles by the length of Alternate Care stay and found some factors which appear to be correlated with longer stays.

There are two areas that might be explored more fully in a future study. One is to gather more precise information on the meaning of a patient having a history of being "non-compliant with the care plan." The other is to gather more precise data on the mental status of the patients. Because it was the intent of this study to identify barriers to accessing appropriate long term care services, baseline questions on both of these issues were used. Given the prevalence found, future research might delineate these problems further. It would be helpful to have more specificity regarding "non-compliant" and "violent" behaviors.

While the recommendations put forward in these recommendations are intended to be comprehensive, there remains a question whether special consideration should be given to the needs of working age people who require long term care services. While the Finger Lakes Region developed a Pediatric Chronic Care Plan in the mid-90's, there has never been a focused assessment of the needs of working age adults. In this study, nearly 50% of the population was under 60 years of age. While gaps in services and barriers to care were addressed for the population as a whole, it may be appropriate for a separate study to look more holistically at the needs of working age adults as their social, developmental, recreational, and spiritual needs may be quite different from older adults with comparable physical health care needs.

Applied research studies of this type are useful in focusing the community's attention on a problem, documenting the profile of the affected populations, and documenting barriers to their receiving the care they need in a timely manner. By gathering strategic community representatives together to review the data, and developing consensus on approaches to address the multiple problems that result in alternate care, it is possible to develop a series of strategies that multiple stakeholders are prepared to address collectively. Ultimately it may be most helpful to understand alternate care as a symptom of an array of problems which affect the organization, financing and delivery of care to elders and those who are chronically ill. This study provides an opportunity to focus on those strategies the community believes can improve timely access to appropriate care for vulnerable people.

# Appendix 1

## **LONG-TERM CARE COUNCIL MAJOR THEMES IDENTIFIED BY RANK**

- I. Care Management and Social Work (15 votes – ranked first)**
  - a. There is a lack of integration of care from hospital to facility to home discharge to home care.
  - b. Coordinated discharge planning is needed.
  - c. There are very few trained geriatric social workers.
  - d. Services are too costly for consumers.
  - e. There is a lack of funding and insurance reimbursement for case management.
  - f. There is a shortage of social service workers, resulting in huge caseloads.
  - g. Private care managers have a waiting list of 6-8 weeks.
  - h. A difficult case is hard to refer.
  - i. There is a lack of linkages to social workers and case managers with physician offices. Physician offices need to integrate case managers into their offices.
  - j. Physicians need case management education.
  - k. Culturally diverse and multi-lingual social workers are needed.
  - l. In the Latino community, there is a lack of case managers to help the elderly access services.
  - m. Long-term care services and NY Connects need to be advertised, as people don't know where to turn for help.
- II. Caregiver Issues (14 Votes – ranked second)**
  - a. There are inadequate available in-home care options when a caregiver is not available.
  - b. There is a lack of support for caregivers other than those caring for individuals with dementia.
  - c. Weekend and/or evening help is often not available.
  - d. There are problems with coordination of care and system navigation.
  - e. Caregivers suffer stress and burnout, and do not know where to get help with service and finances.

**Workforce (14 Votes – tied for second)**

  - a. There is a shortage of registered nurses and certified nursing assistants.
  - b. Primary care physicians are needed to take community-dwelling, frail elders as patients.
  - c. There is a need for geriatric physicians and geriatric psychologists.
  - d. There is a need for geriatric social workers able to address co-morbidities in the elderly
  - e. In certain parts of the county, home health care is unreliable.
- III. Financial, Legal, Health Insurance and Entitlement (12 Votes – ranked third)**
  - a. Some seniors carry serious credit card debt.
  - b. Some seniors are unable to pay their bills, and live in poverty.
  - c. Rent assistance is needed.



- d. Financial exploitation and/or abuse continue to occur.
- e. The structure of long-term care financing makes it difficult to keep people in lower levels of care.
- f. Guardianship is needed for some seniors.
- g. Medicare payment issues exist, including challenges with emergency versus chronic care.
- h. Many do not have sufficient prescription drug coverage.

**IV. Housing (7 Votes – ranked fourth)**

- a. Funds for assisted living must be identified.
- b. More affordable assisted living for Medicaid and low-income individuals is needed.
- c. Assisted living facilities prevent nursing home placement, however, when the individual becomes frail or needs higher levels of care, s/he is brought to the hospital and from there, placed in a nursing home. By this time, all of the individual's resources have been depleted.
- d. There is a need for licensed enriched housing and more NORC programs.
- e. Grandparents raising grandchildren need appropriate, safe housing.
- f. Housing is needed for the following: dialysis patients, individuals with general behavior issues, and the developmentally disabled senior.

**V. Transportation (4 Votes – ranked fifth)**

- a. A rigid and inadequate system makes many services inaccessible.
- b. There is a lack of transportation for dialysis treatment; transportation three times per week is not always available.
- c. Transportation to Adult Day Programs is needed.
- d. It is difficult to recruit volunteer drivers due to the concern about liability.
- e. Non-English speaking seniors need transportation to centers.
- f. there is a lack of transportation coordination.
- g. A “transportation specialist” is needed to arrange rides for individuals.
- h. A transportation infrastructure should be developed in the suburban towns and villages. Where possible, services (e.g., grocery delivery, prescription delivery, house calls, etc.) should be brought to the individual.

**VI. Behavioral Health – Mental Health and Substance Abuse Services (2 Votes – ranked sixth)**

- a. There is a great difficulty placing people who are SPMI in nursing facilities.
- b. There is a prevalence of mental health issues, including depression.
- c. There is a lack of substance abuse services.

**Home Care (2 Votes – tied for sixth)**

- a. Monroe County needs a Personal Care Assistant Program under Medicaid.
- b. Limited home care for rural individuals.
- c. The workforce issue is an overarching one.
- d. The need and desire for consumer directed care is growing, due to the workforce shortage.
- e. EISEP has limited slots available.
- f. There is a lack of chore services.

# Appendix 2

## Care Management Work Group

**Key Problem Identified:** Many patients, not just frail elders, suffer from a lack of oversight and continuity in their care, particularly during transitions from one provider to another or from hospitals to rehabilitation centers, nursing facilities, or homes.

<b>Contributors To the Problem</b>	<i>Individual</i>	<ul style="list-style-type: none"> <li>• Complex medical and social factors</li> <li>• Older, sicker, poorer when they come into the system</li> <li>• Lack of resources to pay for home care</li> <li>• People avoid their problems until there is a crisis</li> <li>• Family not available or unwilling to help</li> <li>• Individual in crisis</li> <li>• Caregiver is burnt out or frail</li> <li>• Don't understand choices</li> <li>• Lack of knowledge about community based service</li> <li>• Lack of proactive thought and planning for LTC &amp; elder issues.</li> <li>• Disabled (age 45 – 65) are without resources – very limited income</li> </ul>
	<i>Community</i>	<ul style="list-style-type: none"> <li>• Norm has become to send elderly to hospital when in crisis</li> <li>• Reliance on health care providers to coordinate care during brief visit or hospital stay, without incentives for providers to do so, leads to inadequate care coordination.</li> <li>• PCPs don't have time, expertise or avoid issues because they don't have an answer</li> <li>• Lack of affordable housing</li> </ul>
	<i>Hospital</i>	<ul style="list-style-type: none"> <li>• Hospitals have to move people fast</li> <li>• Hospitals have multiple issues to deal with (Medicaid to financial to family)</li> <li>• Hospital has become "community crisis center"</li> <li>• Financial and legal issues for hospitals</li> <li>• Hospitals don't know when patients have EISEP case manager</li> <li>• Cases are too complicated – it takes many different specialists to help at time of crisis</li> </ul>
	<i>System / Reimbursement</i>	<ul style="list-style-type: none"> <li>• There are no financing incentive to look for HCBS alternatives</li> <li>• Care coordination isn't likely to improve unless there are mechanisms in place to pay for it. The current fee-for-service model offers few incentives for providers to ensure smooth transitions, provide anticipatory guidance, or follow-up with patients.</li> <li>• Too much duplication of intake/assessment process</li> <li>• Few settings actually integrate social services with medical services.</li> <li>• Financial realities for service providers and length of stay issues</li> <li>• Medicaid eligibility and regulations often determines direction of case</li> <li>• Medicaid – lack of knowledge and misinformation about Medicaid</li> <li>• Lack of resources to pay for home care – insurance, private pay and workforce</li> </ul>
<b>Methods for Creating Change</b>		<ul style="list-style-type: none"> <li>• Need access to information -Electronic medical records could help to smooth the transfer of medical information, across institutions, such as the RHIO</li> <li>• Widespread reform requiring changes to the financing of care delivery and other system-wide changes.</li> <li>• Prevention - Education and Information about community services and financial planning</li> <li>• Connect people to preventive services, such as EISEP &amp; Eldersource</li> <li>• Need to create protocol for physicians to ask standardized questions @ home situation and discharge plans prior to surgery or admission</li> <li>• Require impact assessment at point of intervention</li> </ul>
<b>Promising Programs Identified by Work Group</b>		<ul style="list-style-type: none"> <li>• Eldersource/Wilson Center Pilot project – intensive care management to caregiver and patient of PCP.</li> <li>• Strong &amp; Eldersource pilot project</li> <li>• Unity Project</li> <li>• Eldersource/Wilson Health Center Pilot – care managers</li> <li>• Vermont's HCBS Waiver</li> </ul>
<b>Other Data/ Information Needed</b>		<ul style="list-style-type: none"> <li>• Nursing Home Diversion</li> <li>• Adult Protective</li> </ul>

## I. Community Initiatives to Address ALC

- a. Current – Excellus Behavioral Health Group advocating for changes to regulations to add step down neurobehavioral beds (which in fact are becoming a lower level of gero-psychiatric beds) in nursing homes.
- b. 2008 – Mental Health Group developed guide for aging mental health services.
- c. Monroe County developed DHS teams to facilitate processing Medicaid applications of hospitalized patients.
- d. 2008- FLHSA supported renovation of existing areas of MCH for 49 single beds, including reactivation of 29 beds which will increase the number of single rooms, increase operational capacity without increasing licensed capacity and add 12 dialysis stations.
- e. 2008- FLHSA recommended replacement of Park Ridge Nursing Homes with four duplex cottages of 20 beds (all single rooms) each and a 40 bed short stay SNF rehabilitation unit; . It provides 60 beds of traditional and specialized long term care to residents on one floor. Another floor provides comprehensive rehabilitation, 48-hour post-operative care, wound care management, and IV antibiotic care for short stay residents. The entire facility accepts patients who have MRSA and ORSA infections, patients who require the use of wound vacs or Clinitron beds, and bariatric patients. The facility also provides care for patients requiring PIC lines and enteral feeding, as well as patients with dementia. The facility accepts patients who are awaiting Medicaid approval and those who are in the process of having guardianship established.
- f. 2008- FLHSA recommended replacement of Crest Manor. The new facility is designed to enhance the living arrangements for people in need of rehabilitation and people with Alzheimer's disease. It will also expand the respite capacity in the community and it will also provide all single rooms, and expand the facility's flexibility to accept more male patients, more patients who require infection control protocols and a more soothing environment for people with dementia.
- g. 2007- FLHSA developed renovation and replacement criteria for nursing homes which address current bed need; access for types of people currently on ALC including but not limited to: males, people of color, people with behavioral considerations, people with infections, people needing wound care, hi tech, etc.
- h. 2007- FLHSA developed proposal for Long Term Care Hospital which the state has indicated it does not want to address;
- i. 2007- FLHSA recommended conversion of 54 skilled nursing home beds at Fairport Baptist Home to 33 Assisted Living Beds, with the proviso that 11 would be used for SSI residents;
- j. 2007- FLHSA recommended renovations at Rochester Friendly Home which will increase the number of private beds to address need for greater flexibility for men

and people with infections; have at least 6 beds for bariatric patients; provide 24/7 IV meds; includes a series of actions to make the facility more proactive in marketing the facility to and admitting people of color;

- k. FLHSA began to assess all nursing home applications for their historic access to people of color, and applied contingencies to approvals where accessibility had historically been inadequate;
- l. 2004- FLHSA recommended a 10 bed vent unit at Park Ridge, opened in 2005.
- m. 2004- FLHSA updated Hospice Plan led to expansion of hospice beds;
- n. 2002 to present- length of stay in nursing homes declined as rehab admissions increased; the increase in return of people to the community increased admission rates.
- o. 2000 –decline in social day care began;
- p. 1985-2000 Major expansion in senior housing options, including assistive housing.
- q. Mid-90's FLHSA completed a Pediatric Chronic Care Plan defined a comprehensive array of pediatric long term care services both in the community and the need to renovate MCH into a modern facility for children and young adults capable of caring for those requiring ventilator care. Currently recommending establishment of Day Star as a Developmentally Delayed (DD) program that can then be licensed and reimbursed to provide day care for children with complex medical needs;
- r. 1995 VNS and GRHC developed One Caring Place/Hospitality House- a short term congregate living residence that provided room, board, and related services and arranged for CHHA, licensed home care, LTHHC, hospice care and AIDS home care for people who had no available primary care giver. The objectives were to reduce hospital discharge delays, provide an alternative to hospital readmissions, provided respite or transitional care for technology dependent people. The facility had 91% occupancy, but payers would not support the fee for the facility, and VNS pulled out after contributing more than \$500,000. I have no record of the financial contributions of other providers.
- s. 1993- Specialty nursing home beds began to come on line;
- t. 1990-2002- Major expansion of adult day health care;
- u. 1990 Initiation of the Independent Living Services (ILS) project which integrated primary, acute, long term care and residential services for nursing home eligible population. The program expanded from 100-400 slots.
- v. Barker and Mott Geriatric Physicians in a nursing home project demonstrated in Aberdeen and Alaimo Nursing Homes that when nursing homes hired a physician, it was possible to decrease hospital admissions by early identification and treatment of medical problems in place.
- w. 1987 Nursing Home Plan for 1993: identified the need for chronic ventilator care; care of people with developmental disabilities, and attempted to deal with needs of neuro-behavioral and psycho-geriatric needs, and the need for dialysis in

strategically located nursing homes. With the result that the following special care beds have been developed in Monroe County. (30 vents, 20 dialysis +12 under development, 15 neurobehavioral and 146 multiply impaired, 37 for people with DD, and 289 for ALC patients (beds for multiply impaired, no program or reimbursement allowable).

- x. 1982-1984 Park Ridge Geriatric Med/Surg Unit- 12 beds were dedicated to using rehabilitation approaches to keep medical and surgical geriatric patients functional and preventing iatrogenically induced complications during their stay. The results indicated that patients admitted to the unit had higher functional scores on discharge, even though they were higher on admission than the control patients. The improvement in their functional status increased the rate of discharge home and made the patients easier to place at lower levels of care. Patients also had lower rates of readmission than control patients. The study population had lower ancillary charges due to maintaining their function.
- y. 1980's developed and periodically updated plans for hospice, LTHHCP, and adult day health care and CHHA services with the result that all identified needs were addressed.
- z. Mid-80's case mix adjusted nursing home reimbursement, which included private pay patients in assessing the facilities' case mix. This incented facilities to take higher care patients (including private pays) over lower care patients.
- aa. 1979 approval of 175 beds; development of Medicaid access requirement; Court decision upholding Medicaid access.
- ab. 1978 opening of Monroe County Long Term Care Program ACCESS intended to expand use of community based LTC services, provided first waived services including home modification and case management.
- ac. Note: see Appendix 6 for initiatives that were identified after the document was completed.

## **II. Interventions to Address Patients' Behavioral Health Needs**

### **The Rochester Regional Geriatric Mental Health Alliance**

The Rochester Regional Geriatric Mental Health Alliance was established in 2007 and follows the creation of the Geriatric Mental Health Alliance of New York. That Alliance was created in 2003 to advocate for statewide mental health policies that will improve services for older adults, and for changes laying the groundwork for developing an adequate response to the mental health needs of the elder boom. In 2005, working with other advocacy groups, the Alliance helped to win passage of the Geriatric Mental Health Act. Signed into law by Governor Pataki, it is the first of its kind in the nation.

A continuing goal of the New York City based Alliance is to build a network of people across the state to support efforts and it has encouraged local Mental Health Association chapters to take the lead in facilitating these efforts. Our Alliance has been created in response to this need.

In addition to providing a vehicle to work with the state alliance in promoting broader initiatives and efforts, our local Alliance represents the specific interests of our community, giving us a voice in shaping the state agenda.

As an impartial entity, The Mental Health Association agreed to facilitate the effort.

As of December 2008, our local Alliance boasts a membership base of 39 persons representing aging and mental health services, health insurers, chemical dependency, minority services, and professional associations

One of the major focuses of the Alliance is to address public policy issues. In addition, we have recently developed a community-wide directory of geriatric mental health services. Along with distributing this Guide, we are using it as a tool to guide us in identifying future efforts. One of our next tasks is to focus on treatment gaps in the community for older adults with co-occurring disorders. We are beginning a community dialogue to design a streamlined clinical care pathway for this population.

### **III. Draft**

#### *Excellus Initiative: Neuro-Behavioral Bed Capacity Proposal*

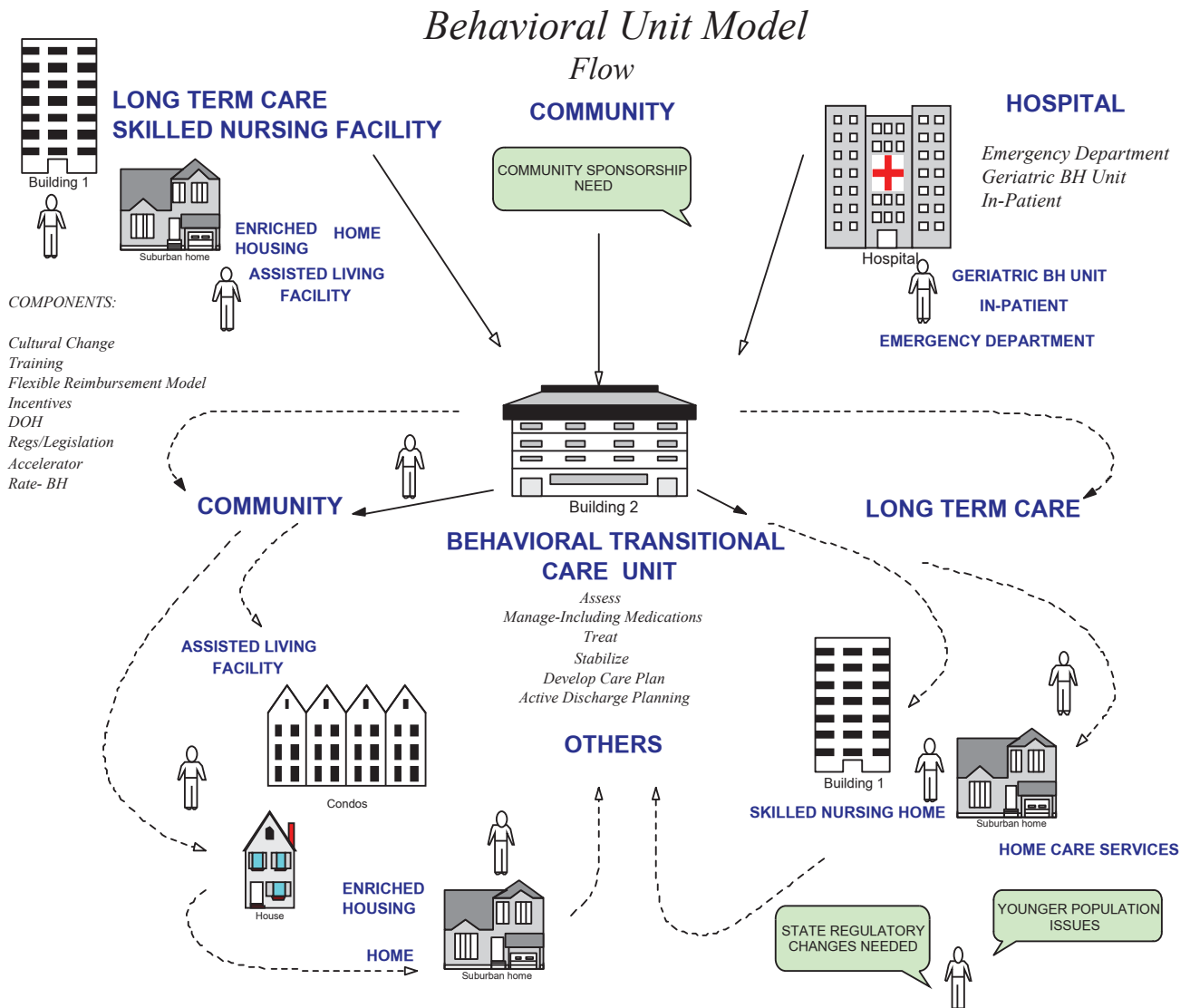
#### **Project Scope**

The Scope of this project is development of a model of community-based behavioral health transitional care unit that would serve to assess, stabilize and triage patients with behavioral patients who require care in a nursing home setting. Project scope also encompasses a process of presenting and testing the demonstration model with a variety of community stakeholders to test its salience and practicality. A final aspect of the Project Scope is determining the availability of a multi-faceted funding stream from within the stakeholder community that could be used to support the model program over time. Specific objectives for the Project include:

- Identify, examine, and plan for the management of barriers to the expedited placement of patients with behavioral care requirements in long term care settings, (avoid potential re-hospitalizations, and improve the quality of care provided while enhancing the patients' and families' quality of life.
- Create a model program for centralized care of patients with behavioral requirements, one that would expedite discharge, decrease unnecessary hospital stays, and facilitate patient access to the lowest and most appropriate level of long term care;
- Articulate interim strategies for funding the model program in a pilot phase while mobilizing influence to restructure Medicaid, Medicare and commercial insurance reimbursement so that behavioral care in long term care settings is adequate.



## IV. Behavioral Unit Model Diagram



# Appendix 4

Hospital \_\_\_\_\_ ALC Patient Survey Nos. \_\_\_\_\_

Admission Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Length of Stay to Date: Acute Days \_\_\_\_\_ ALC Days \_\_\_\_\_

Current Location: \_\_\_\_ Emergency Dept \_\_\_\_ Psychiatric Unit \_\_\_\_ M/S Unit  
\_\_\_\_ Other, Specify \_\_\_\_\_

Reason for Hospitalization: Primary Dx (ICD9) \_\_\_\_\_ NYS DRG \_\_\_\_\_

Patient Characteristics: Age \_\_\_\_\_ Gender \_\_\_\_ M \_\_\_\_ F

Race/Ethnicity \_\_\_\_ White/non-Latino \_\_\_\_ Black/non-Latino \_\_\_\_ Latino  
\_\_\_\_ Other/non-Latino

US Citizen \_\_\_\_ Yes \_\_\_\_ No

Primary Language of Patient, if other than English \_\_\_\_\_

Residence/Living Arrangement Prior to Admission: Zip Code \_\_\_\_\_

(Select one of the following)

\_\_\_\_ Home alone, **no** services      \_\_\_\_ Home with other(s), **no** services  
\_\_\_\_ Home alone, **with** services      \_\_\_\_ Home with other(s), **with** services

Specify Services: \_\_\_\_ Housekeeping \_\_\_\_ Personal care/HHA \_\_\_\_ Skilled nursing  
\_\_\_\_ Therapies \_\_\_\_ Day care \_\_\_\_ MOW \_\_\_\_ Hospice \_\_\_\_ Adult Home/ALP  
\_\_\_\_ Home for the Dying \_\_\_\_ Nursing Home \_\_\_\_ Shelter

Other, Specify \_\_\_\_\_

Care Giver situation (check all that apply)

\_\_\_\_ No care giver available \_\_\_\_ Care giver limited: availability, ability, cooperation  
\_\_\_\_ Care giver lacks needed support \_\_\_\_ Care giver burned out  
\_\_\_\_ Guardianship is needed \_\_\_\_ Uncooperative family

Specialty Care Needed (check all that apply)

\_\_\_\_ Injections \_\_\_\_ IV therapy \_\_\_\_ TPN \_\_\_\_ Obesity \_\_\_\_ Ventilator  
\_\_\_\_ Infectious Disease \_\_\_\_ Dialysis \_\_\_\_ Wound Care \_\_\_\_ VAC Wound Care  
\_\_\_\_ Specialty Mattress \_\_\_\_ Transportation \_\_\_\_ Costly Medications  
\_\_\_\_ Medically Complex \_\_\_\_ Other, Specify \_\_\_\_\_

Expected Secondary Payer for Post-Discharge Services: \_\_\_\_\_

Current Medicaid Status: \_\_\_\_ Pending \_\_\_\_ Chronic Care \_\_\_\_ Spenddown  
\_\_\_\_ Not currently eligible \_\_\_\_ Unknown



**Discharge Considerations/Concerns/Barriers** (enter/check all that apply):

Co-morbidities: \_\_\_\_\_

Mobility Limitations: \_\_\_\_\_ Outside \_\_\_\_\_ Inside \_\_\_\_\_

Assistive Devices Required, specify \_\_\_\_\_

Incontinent: \_\_\_\_\_ Urine \_\_\_\_\_ Feces

Barriers to Communication: \_\_\_\_\_ Blind \_\_\_\_\_ Visual impairment affects functioning

\_\_\_\_\_ Deaf \_\_\_\_\_ Hearing impairment affects functioning \_\_\_\_\_ English NOT Primary Language

Mental Status: \_\_\_\_\_ Cognitively impaired: \_\_\_\_\_ DD \_\_\_\_\_ TBI \_\_\_\_\_ Dementia \_\_\_\_\_ Depressed

\_\_\_\_\_ Suicidal \_\_\_\_\_ Homicidal \_\_\_\_\_ History of Psychosis \_\_\_\_\_ Non-compliant with medication

\_\_\_\_\_ Untreated active MH issue \_\_\_\_\_ Other, specify \_\_\_\_\_

Behavioral: \_\_\_\_\_ History of non-compliance with care plan \_\_\_\_\_ History of violence

\_\_\_\_\_ History of arson \_\_\_\_\_ History of sexually inappropriate behavior \_\_\_\_\_ Verbally disruptive

\_\_\_\_\_ Physically disruptive \_\_\_\_\_ Physical restraints required \_\_\_\_\_ Wanderer

\_\_\_\_\_ Other, specify \_\_\_\_\_

Substance Use/Abuse: \_\_\_\_\_ Alcoholism \_\_\_\_\_ Street drugs \_\_\_\_\_ Abuse of prescription

and/or OTC medications \_\_\_\_\_ Methadone maintenance \_\_\_\_\_ Smoking issues

\_\_\_\_\_ Other, specify \_\_\_\_\_

Criminal History: \_\_\_\_\_ Yes

What are the **top three** (in order) barriers that are preventing this patient from being discharged/placed?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**What plan are you trying to arrange for this patient?**

\_\_\_\_\_ Home, no services \_\_\_\_\_ Home with services, specify services \_\_\_\_\_

\_\_\_\_\_ Adult Home/ALP \_\_\_\_\_ Nursing Home \_\_\_\_\_ Home for the Dying \_\_\_\_\_ Inpatient Hospice

\_\_\_\_\_ VA \_\_\_\_\_ Psychiatric Care \_\_\_\_\_ Other, specify \_\_\_\_\_

## Appendix 5

### Specialty Beds in Skilled Nursing Facilities

Ventilator		
Clifton Springs	8	
DeMay Living Center	10	
Highlands at Brighton	20	
Mercycare	8	
Unity @ St. Mary's	10	
Total	56	
MCH Ped.	5 *	
not in operation		
Dialysis		
Highlands at Pittsford	4	
Mercycare	12	
MCH Pending		12
Clifton Springs		1
Unity @ Genesee St.	20	
Total	36	13

## Appendix 6

### **ADDENDUM OF ADDITIONAL INITIATIVES THAT MAY HAVE REDUCED ALTERNATE CARE WHICH WERE REPORTED AFTER THE REPORT WAS CONCLUDED**

1. The Community-wide End-of-Life/Palliative Care Initiatives
  - a. Community Conversations on Compassionate Care,
  - b. MOLST,
  - c. Community Principles of Pain Management,
  - d. the community web site: [www.CompassionAndSupport.org](http://www.CompassionAndSupport.org).
  - e. Peg Tube [Guidelines@CompassionNet.net](mailto:Guidelines@CompassionNet.net)
  - f. Increased palliative care medical personnel recruited as a result of Excellus being the first plan in the country to pay for palliative medicine physicians.
  - g. Including in the MOLST patient choice options the decision not to be hospitalized;
  - h. Expansion of the number of homes for the dying which now total 8 in Monroe County and 6 in surrounding counties; (These facilities allow people without primary care giver support to utilize home hospice in a surrogate family home environment.)





## **MONROE COUNTY OFFICE FOR AGING**

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